FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037317

Facility Name: Lexington of Elmhurst

Address: 420 W. Butterfield Road (Number) Elmhurst (City) 60126 (Zip Code)

County: Dupage

Telephone Number: (630) 832-2300 **Fax #** (630) 832-7043

IDPA ID Number: 363682838001

Date of Initial License for Current Owners: 11/12/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,900	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,900	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,163	9,216	9,894	34,273	8
9	SNF/PED					9
10	ICF	11,238	5,164	303	16,705	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,401	14,380	10,197	50,978	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.86%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/12/91

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 150 and days of care provided 8,212

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	300,423	31,264	11,580	343,267		343,267		343,267			1
2	Food Purchase		236,451		236,451		236,451	(10,412)	226,039			2
3	Housekeeping	199,761	27,020		226,781		226,781	217	226,998			3
4	Laundry	50,425	17,269		67,694		67,694	(1,030)	66,664			4
5	Heat and Other Utilities			194,089	194,089		194,089	2,480	196,569			5
6	Maintenance	35,354		75,015	110,369		110,369	31,856	142,225			6
7	Other (specify):* Allocated Benefits							3,585	3,585			7
8	**TOTAL General Services**	585,963	312,004	280,684	1,178,651		1,178,651	26,696	1,205,347			8
	B. Health Care and Programs											
9	Medical Director			18,500	18,500		18,500		18,500			9
10	Nursing and Medical Records	2,203,610	144,318	147,238	2,495,166		2,495,166	41,879	2,537,045			10
10a	Therapy			668,468	668,468		668,468		668,468			10a
11	Activities	180,339	19,291	3,185	202,815		202,815		202,815			11
12	Social Services	35,228		3,161	38,389		38,389		38,389			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Allocated Benefits							5,064	5,064			15
16	**TOTAL Health Care and Programs**	2,419,177	163,609	840,552	3,423,338		3,423,338	46,943	3,470,281			16
	C. General Administration											
17	Administrative	99,934		728,194	828,128		828,128	(657,708)	170,420			17
18	Directors Fees											18
19	Professional Services			60,093	60,093		60,093	9,778	69,871			19
20	Dues, Fees, Subscriptions & Promotions			50,293	50,293		50,293	(349)	49,944			20
21	Clerical & General Office Expenses	163,140	33,576	16,936	213,652		213,652	198,938	412,590			21
22	Employee Benefits & Payroll Taxes			459,920	459,920		459,920	10,237	470,157			22
23	Inservice Training & Education			370	370		370		370			23
24	Travel and Seminar			3,624	3,624		3,624	2,705	6,329			24
25	Other Admin. Staff Transportation			159	159		159	6,958	7,117			25
26	Insurance-Prop.Liab.Malpractice			171,434	171,434		171,434	3,098	174,532			26
27	Other (specify):* Allocated Benefits							30,549	30,549			27
28	**TOTAL General Administration**	263,074	33,576	1,491,023	1,787,673		1,787,673	(395,794)	1,391,879			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,268,214	509,189	2,612,259	6,389,662		6,389,662	(322,155)	6,067,507			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lexington of Elmhurst #0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			51,704	51,704		51,704	140,679	192,383			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			951	951		951	234,318	235,269			32
33	Real Estate Taxes							61,212	61,212			33
34	Rent-Facility & Grounds			839,059	839,059		839,059	(838,060)	999			34
35	Rent-Equipment & Vehicles			4,092	4,092		4,092	2,107	6,199			35
36	Other (specify):*											36
37	**TOTAL Ownership**			895,806	895,806		895,806	(399,744)	496,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		243,388	814	244,202		244,202		244,202			39
40	Barber and Beauty Shops			30,640	30,640		30,640		30,640			40
41	Coffee and Gift Shops			1,977	1,977		1,977		1,977			41
42	Provider Participation Fee			82,350	82,350		82,350		82,350			42
43	Other (specify):* Nonallowable Costs			158,066	158,066		158,066	(158,066)				43
44	**TOTAL Special Cost Centers**		243,388	273,847	517,235		517,235	(158,066)	359,169			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,268,214	752,577	3,781,912	7,802,703		7,802,703	(879,965)	6,922,738			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(175)	2		4
5	Telephone, TV & Radio in Resident Rooms	(409)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,030)	4		8
9	Non-Straightline Depreciation	1,692	30		9
10	Interest and Other Investment Income	(10,753)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,278)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,093)	43		18
19	Entertainment				19
20	Contributions	(3,410)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(110,250)	43		24
25	Fund Raising, Advertising and Promotional	(11,263)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,000)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule A	(16,688)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (172,657)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(707,308)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (707,308)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (879,965)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/04 - 12/31/04

Schedule A

Schedule VI. Adjustment detail
Line 29, Other

Description	Amount	Reference
Disallow radiology	(5,720)	43
Disallow laboratory	(4,155)	43
Disallow personal item replacement	(2,488)	43
Nonallowable collections	(2,394)	19
Miscellaneous income offset	(14)	21
Nonallowable Chamber of Commerce dues	(1,000)	20
Disallow out of period legal fees	(917)	19
Total	(16,688)	

See Accountants' Compilation Report

Lexington of Elmhurst

ID# 0037317

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(175)	0	0	0	0	0	0	0	0	0	0	(175)	2
3	Housekeeping	0	0	217	0	0	0	0	0	0	0	0	217	3
4	Laundry	(1,030)	0	0	0	0	0	0	0	0	0	0	(1,030)	4
5	Heat and Other Utilities	0	0	2,480	0	0	0	0	0	0	0	0	2,480	5
6	Maintenance	0	0	31,856	0	0	0	0	0	0	0	0	31,856	6
7	Other (specify):*	0	0	3,585	0	0	0	0	0	0	0	0	3,585	7
8	**TOTAL General Services**	(1,205)	0	38,138	0	0	0	0	0	0	0	0	36,933	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	41,879	0	0	0	0	0	0	0	0	41,879	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	5,064	0	0	0	0	0	0	0	0	5,064	15
16	**TOTAL Health Care and Programs**	0	0	46,943	0	0	0	0	0	0	0	0	46,943	16
	C. General Administration													
17	Administrative	0	0	70,486	(728,194)	0	0	0	0	0	0	0	(657,708)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,298	12,839	0	0	0	0	0	0	0	0	14,137	19
20	Fees, Subscriptions & Promotions	0	0	651	0	0	0	0	0	0	0	0	651	20
21	Clerical & General Office Expenses	0	49	198,903	0	0	0	0	0	0	0	0	198,952	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,705	0	0	0	0	0	0	0	0	2,705	24
25	Other Admin. Staff Transportation	0	0	0	6,958	0	0	0	0	0	0	0	6,958	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	3,098	0	0	0	0	0	0	0	3,098	26
27	Other (specify):*	0	0	0	30,549	0	0	0	0	0	0	0	30,549	27
28	**TOTAL General Administration**	0	1,347	285,584	(687,589)	0	0	0	0	0	0	0	(400,658)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,205)	1,347	370,665	(687,589)	0	0	0	0	0	0	0	(316,782)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,692	117,957	0	21,030	0	0	0	0	0	0	0	140,679	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,753)	244,816	0	255	0	0	0	0	0	0	0	234,318	32
33	Real Estate Taxes	0	59,059	0	1,105	0	0	0	0	0	0	0	60,164	33
34	Rent-Facility & Grounds	0	(839,059)	0	999	0	0	0	0	0	0	0	(838,060)	34
35	Rent-Equipment & Vehicles	0	0	0	2,107	0	0	0	0	0	0	0	2,107	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,061)	(417,227)	0	25,496	0	0	0	0	0	0	0	(400,792)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(145,703)	0	0	0	0	0	0	0	0	0	0	(145,703)	43
44	**TOTAL Special Cost Centers**	(145,703)	0	0	0	0	0	0	0	0	0	0	(145,703)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(155,969)	(415,880)	370,665	(662,093)	0	0	0	0	0	0	0	(863,277)	45

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of Elmhurst		
See attached Schedule B		See attached Schedule B		II Ltd. Ptsp.	Elmhurst	Real estate ptsp.
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services II, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 839,059	Sambell of Elmhurst II Limited Partnership	**	$	$ (839,059)	1
2	V	19	Professional fees		Sambell of Elmhurst II Limited Partnership	**	1,298	1,298	2
3	V	21	Bank charges		Sambell of Elmhurst II Limited Partnership	**	49	49	3
4	V	30	Depreciation		Sambell of Elmhurst II Limited Partnership	**	117,957	117,957	4
5	V	32	Interest expense		Sambell of Elmhurst II Limited Partnership	**	242,387	242,387	5
6	V	32	Amortization of mortgage costs		Sambell of Elmhurst II Limited Partnership	**	2,429	2,429	6
7	V	33	Property taxes		Sambell of Elmhurst II Limited Partnership	**	59,059	59,059	7
8	V								8
9	V								9
10	V				** The owners of Lexington Health Care Center of Elmhurst, Inc. own 100%				10
11	V				of Sambell of Elmhurst II Limited Partnership				11
12	V								12
13	V								13
14	Total			$ 839,059			$ 423,179	$ * (415,880)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/04 - 12/31/04

Schedule B

VII. Related Parties
Owners

Name	Ownership %
James Samatas Discretionary Trust	16.66%
John Samatas Discretionary Trust	16.67%
Cynthia Thiem Discretionary Trust	16.67%
David S. Bell Revocable Trust	12.50%
Jeffrey J. Bell Revocable Trust	12.50%
Lawrence W. Bell Revocable Trust	12.50%
David S. Bell 2001 Trust	4.16%
Jeffrey J. Bell 2001 Trust	4.17%
Lawrence W. Bell 2001 Trust	4.17%

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 217	$ 217	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	2,358	2,358	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	62	62	17
18	V	5	Utilities - maintenance office		Royal Management Corp.	**	60	60	18
19	V	6	Management allocation - salaries		Royal Management Corp.	**	29,646	29,646	19
20	V	6	Repairs & maintenance		Royal Management Corp.	**	2,210	2,210	20
21	V	7	Management allocation - employee benefits		Royal Management Corp.	**	3,585	3,585	21
22	V	10	Management allocation - salaries		Royal Management Corp.	**	41,879	41,879	22
23	V	15	Management allocation - employee benefits		Royal Management Corp.	**	5,064	5,064	23
24	V	17	Management allocation - salaries		Royal Management Corp.	**	70,486	70,486	24
25	V	19	Computer consultant & supplies		Royal Management Corp.	**	7,891	7,891	25
26	V	19	Professional fees		Royal Management Corp.	**	4,948	4,948	26
27	V	20	Dues & subscriptions		Royal Management Corp.	**	583	583	27
28	V	20	Licenses, permits & inspections		Royal Management Corp.	**	16	16	28
29	V	20	Advertising - help wanted		Royal Management Corp.	**	52	52	29
30	V	21	Management allocation - salaries		Royal Management Corp.	**	182,144	182,144	30
31	V	21	Bank charges		Royal Management Corp.	**	1,449	1,449	31
32	V	21	Office supplies & printing		Royal Management Corp.	**	6,156	6,156	32
33	V	21	Postage		Royal Management Corp.	**	2,522	2,522	33
34	V	21	Telephone		Royal Management Corp.	**	6,632	6,632	34
35	V	24	Travel & seminar		Royal Management Corp.	**	2,705	2,705	35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 370,665	$ * 370,665	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 6,958	$ 6,958	15
16	V	26	Insurance general		Royal Management Corp.	**	3,098	3,098	16
17	V	27	Management allocation - employee benefits		Royal Management Corp.	**	30,549	30,549	17
18	V	30	Depreciation - vehicles		Royal Management Corp.	**	2,257	2,257	18
19	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	4,893	4,893	19
20	V	30	Depreciation - equipment		Royal Management Corp.	**	13,880	13,880	20
21	V	32	Interest		Royal Management Corp.	**	255	255	21
22	V	33	Property taxes		Royal Management Corp.	**	1,105	1,105	22
23	V	34	Rent expense		Royal Management Corp.	**	999	999	23
24	V	35	Equipment rental		Royal Management Corp.	**	2,107	2,107	24
25	V	17	Management fees	728,194	Royal Management Corp.	**		(728,194)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		** Certain owners of Lexington Health Care Center of Elmhurst, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 728,194			$ 66,101	$ * (662,093)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	16.66%	See Schedule C	3	6%	Salary	$ 23,455	L 17, C 7	1
2	John Samatas	Owner/officer	Admin/Plant Ops	16.67%	See Schedule C	2	4%	Salary	16,754	L 17, C 7	2
3	Cynthia Thiem	Owner/officer	Administrative	16.67%	See Schedule C	2	4%	Salary	16,754	L 17, C 7	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	7%	Salary	4,081	L 17, C 7	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4	8%	Salary	9,442	L 17, C 7	5
6											6
7											7
8											8
9						All individuals work in excess of 40 hours per week.						9
10											10
11											11
12											12
13								TOTAL	$ 70,486		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317 **Schedule C**
1/1/04 - 12/31/04

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	19,211	26,895	19,211	4,679	10,827	80,823
Lexington Health Care Center of Chicago Ridge, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of LaGrange, Inc.	12,174	17,044	12,174	2,965	6,861	51,218
Lexington Health Care Center of Lake Zurich, Inc.	23,790	33,306	23,790	5,795	13,408	100,089
Lexington Health Care Center of Lombard, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Orland Park, Inc.	30,154	42,219	30,154	7,346	16,995	126,868
Lexington Health Care Center of Schaumburg, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Streamwood, Inc.	25,019	35,026	25,019	6,094	14,100	105,258
Lexington Health Care Center of Wheeling, Inc.	24,684	34,557	24,684	6,012	13,912	103,849
Total	210,089	294,125	210,089	51,173	118,403	883,879

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	743,346	10	$ 2,938	$	54,900	$ 217	1
2	5	Utilities - gas & electric	Bed Days	743,346	10	31,920		54,900	2,358	2
3	5	Utilities - water & sewer	Bed Days	743,346	10	846		54,900	62	3
4	5	Utilities - maintenance office	Bed Days	743,346	10	808		54,900	60	4
5	6	Management allocation - salaries	Bed Days	743,346	10	401,410	401,410	54,900	29,646	5
6	6	Repairs & maintenance	Bed Days	743,346	10	29,930		54,900	2,210	6
7	7	Management allocation - employe	Bed Days	743,346	10	48,540		54,900	3,585	7
8	10	Management allocation - salaries	Bed Days	743,346	10	567,037	567,037	54,900	41,879	8
9	15	Management allocation - employe	Bed Days	743,346	10	68,569		54,900	5,064	9
10	17	Management allocation - salaries	Bed Days	743,346	10	954,365	954,365	54,900	70,486	10
11	19	Computer consultant & supplies	Bed Days	743,346	10	106,838		54,900	7,891	11
12	19	Professional fees	Bed Days	743,346	10	66,993		54,900	4,948	12
13	20	Dues & subscriptions	Bed Days	743,346	10	7,893		54,900	583	13
14	20	Licenses, permits & inspections	Bed Days	743,346	10	212		54,900	16	14
15	20	Advertising - help wanted	Bed Days	743,346	10	698		54,900	52	15
16	21	Management allocation - salaries	Bed Days	743,346	10	2,466,223	2,466,223	54,900	182,144	16
17	21	Bank charges	Bed Days	743,346	10	19,618		54,900	1,449	17
18	21	Office supplies & printing	Bed Days	743,346	10	83,348		54,900	6,156	18
19	21	Postage	Bed Days	743,346	10	34,142		54,900	2,522	19
20	21	Telephone	Bed Days	743,346	10	89,797		54,900	6,632	20
21	24	Travel & seminar	Bed Days	743,346	10	36,624		54,900	2,705	21
22										22
23										23
24										24
25	TOTALS					$ 5,018,749	$ 4,389,035		$ 370,665	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	743,346	10	$ 94,217	$	54,900	$ 6,958	1
2	26	Insurance general	Bed Days	743,346	10	41,943		54,900	3,098	2
3	27	Management allocation - employe	Bed Days	743,346	10	413,634		54,900	30,549	3
4	30	Depreciation - vehicles	Bed Days	743,346	10	30,557		54,900	2,257	4
5	30	Depreciation - leasehold improv.	Bed Days	743,346	10	66,255		54,900	4,893	5
6	30	Depreciation - equipment	Bed Days	743,346	10	187,937		54,900	13,880	6
7	32	Interest	Bed Days	743,346	10	3,446		54,900	255	7
8	33	Property taxes	Bed Days	743,346	10	14,963		54,900	1,105	8
9	34	Rent expense	Bed Days	743,346	10	13,526		54,900	999	9
10	35	Equipment rental	Bed Days	743,346	10	28,527		54,900	2,107	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 895,005	$		$ 66,101	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial Services						$	$			$	1
2	II, L.L.C.	X		Mortgage	$32,361.00	12/29/98	4,256,000	3,523,589	01/2008	0.0675	242,387	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank, N.A.		X	Line of Credit	Varies	04/06/02	500,000	175,000	5/31/05	Prime	951	6
7												7
8												8
9	TOTAL Facility Related				$32,361.00		$ 4,756,000	$ 3,698,589			$ 243,338	9
	B. Non-Facility Related*											
10								Amortization of loan costs			2,429	10
11								Interest income offset			(10,753)	11
12												12
13								Allocated from management company			255	13
14	TOTAL Non-Facility Related						$	$			$ (8,069)	14
15	TOTALS (line 9+line14)						$ 4,756,000	$ 3,698,589			$ 235,269	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		$ 72,600	1
	Allocated from Management Company	1,105	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 65,659	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,836)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 66,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 1,048	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 61,212	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	63,573	8
	2000	62,228	9
	2001	65,080	10
	2002	69,897	11
	2003	65,659	12
2004 assessment:		1,575,000	
Equalization factor:		1	
Tax Rate:		0.04141	
Est. 04 taxes payable in 05:		65,218	
Use:		66,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Elmhurst COUNTY Dupage

FACILITY IDPH LICENSE NUMBER 0037317

CONTACT PERSON REGARDING THIS REPORT Ms. Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-14-317-008	Land and building	$ 65,659.00	$ 65,659.00
2.	Royal Management Corp. (Samvest of Lombard II)		$	$
3.	05-01-202-019	Land and building	$ 187,600.00	$ 1,105.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 253,259.00	$ 66,764.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,608 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Lexington Square Life Care of Elmhurst, Inc.: Retirement Community; 342 units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	55,000	1991	$ 1,277,670	1
2	Allocated from management company			11,841	2
3	TOTALS	55,000		$ 1,289,511	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1991	1991	$ 4,110,586	$	35	$ 117,445	$ 117,445	$ 1,541,252	4
5	10		1995	1995	73,302	2,094	35	2,094		20,225	5
6	2		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1992	693	20	35	20		243	9
10	Land Improvement			1995	7,500	500	15	500		4,667	10
11	Fan Coil Units			1996	4,903	140	35	140		1,191	11
12	Patio			1996	2,322	155	15	155		1,316	12
13	Basement rehab			1997	17,151	1,715	10	1,715		12,720	13
14	Baseboards			1997	3,129	313	10	313		2,269	14
15	Wiring			1998	3,090	309	10	309		2,009	15
16	Lobby Tile			1999	19,354	1,935	10	1,935		11,450	16
17	Patio			1999	4,196	280	15	280		1,399	17
18	Automatic Door			2000	1,300	130	10	130		585	18
19	Wallpaper			2000	6,853	685	10	685		3,083	19
20	Patio			2000	1,242	83	15	83		373	20
21	Storage closet for HVAC			2000	3,745	250	15	250		1,124	21
22	Fire pump system			2001	4,141	414	10	414		1,449	22
23	Door releases			2001	4,420	442	10	442		1,547	23
24	Infrared curtains for elevators			2001	3,000	300	10	300		1,050	24
25	Parking lot			2002	2,532	253	10	253		759	25
26	Kitchen tile and plumbing			2002	9,661	966	10	966		2,596	26
27	Elevator upgrade			2002	2,595	519	5	519		1,254	27
28	Facility Rehab-Painting/wallpaper/carpeting			2003	175,252	17,525	10	17,525		33,590	28
29	Facility Rehab-Floor tile/room upgrade			2003	38,140	1,907	20	1,907		3,655	29
30	Facility Rehab-Carpeting			2003	7,860	786	10	786		1,441	30
31	Parking lot			2004	1,999	133	5	133		133	31
32	Roof			2004	15,000	313	20	313		313	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Land improvements - management company	2002	$ 18,663	$	15	$ 1,234	$ 1,234	$ 3,629	37
38	Building - management company	2002	145,197		40	3,548	3,548	10,587	38
39	HVAC, electrical, security system - management company	2003	1,439		30	99	99	137	39
40	Key card system - management company	2004	226		20	12	12	12	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,689,491	$ 32,167		$ 154,505	$ 122,338	$ 1,666,058	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 113,310	$ 15,930	$ 18,134	$ 2,204	3-10 years	$ 55,448	71
72	Current Year Purchases	54,639	3,607	3,607		5-10 years	3,607	72
73	Fully Depreciated Assets	311,602					311,602	73
74	Allocated from Management Company	139,274		13,880	13,880		58,169	74
75	TOTALS	$ 618,825	$ 19,537	$ 35,621	$ 16,084		$ 428,826	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from Management Company			29,147		2,257	2,257		20,027	79
80	TOTALS			$ 29,147	$	$ 2,257	$ 2,257		$ 20,027	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,626,974	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 51,704	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 192,383	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 140,679	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,114,911	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Lobby and therapy room	$	92
93	rehabilitation	24,822	93
94			94
95		$ 24,822	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from management company				999			6
7	TOTAL				$ 999 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,199 Description: Copier - $3,373; Fax machine - $540; Postage machine - $179 Allocated from management company - $2,107
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	3,076	$ 196,081	$	3,076	$ 196,081	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		515	29,027		515	29,027	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		8,004	443,360		8,004	443,360	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				243,388		243,388	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	L39, C3				814			814	13
14	TOTAL			$	11,595	$ 669,282	$ 243,388	11,595	$ 912,670	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 492,020	$ 535,423	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 424,000)	1,730,142	1,730,142	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,255	32,255	6
7	Other Prepaid Expenses	19,652	19,652	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow		27,910	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,274,069	$ 2,345,382	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,684	5,684	12
13	Land		1,289,511	13
14	Buildings, at Historical Cost		4,110,586	14
15	Leasehold Improvements, at Historical Cost	413,380	578,905	15
16	Equipment, at Historical Cost	208,557	647,972	16
17	Accumulated Depreciation (book methods)	(210,104)	(2,114,911)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Construction in progr	24,822	24,822	22
23	Other(specify): Unamortized loan costs		34,014	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 442,339	$ 4,576,583	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,716,408	$ 6,921,965	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 378,073	$ 378,073	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	175,000	175,000	29
30	Accrued Salaries Payable	150,276	150,276	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,932	9,932	31
32	Accrued Real Estate Taxes(Sch.IX-B)		66,000	32
33	Accrued Interest Payable		19,820	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	119,054	79,453	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 832,335	$ 878,554	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,523,589	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,523,589	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 832,335	$ 4,402,143	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,884,073	$ 2,519,822	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,716,408	$ 6,921,965	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/04 - 12/31/04

Schedule E

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	39,601	
Accrued 401 (k) contribution	9,467	9,467
Due to related party	29,135	29,135
Other accrued expenses	40,851	40,851
Total line 36	119,054	79,453

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Investment in Lexington Financial Services, L.L.C. II	56
Vending machine commission income	983
Miscellaneous income	14
Total line 28	1,053

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,899,431	1	
2	Restatements (describe):		2	
3	**Post closing journal entries**	(175,692)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,723,739	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,336,334	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,176,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 160,334	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,884,073	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,268,766	1
2	Discounts and Allowances for all Levels	(717,155)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,551,611	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,198,820	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,198,820	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,609	12
13	Barber and Beauty Care	37,857	13
14	Non-Patient Meals	175	14
15	Telephone, Television and Radio	27	15
16	Rental of Facility Space		16
17	Sale of Drugs	279,771	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,419	19
20	Radiology and X-Ray	6,825	20
21	Other Medical Services	34,087	21
22	Laundry	1,030	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 376,800	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,753	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 10,753	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule E	1,053	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,053	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,139,037	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,178,651	31
32	Health Care	3,423,338	32
33	General Administration	1,787,673	33
	B. Capital Expense		
34	Ownership	895,806	34
	C. Ancillary Expense		
35	Special Cost Centers	434,885	35
36	Provider Participation Fee	82,350	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,802,703	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,336,334	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,336,334	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,894	2,109	$ 92,335	$ 43.78	1
2	Assistant Director of Nursing	2,291	2,471	75,028	30.36	2
3	Registered Nurses	25,577	27,492	804,477	29.26	3
4	Licensed Practical Nurses	11,482	12,320	299,375	24.30	4
5	Nurse Aides & Orderlies	72,862	77,333	861,509	11.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,247	5,702	70,886	12.43	8
9	Activity Director	1,700	1,823	27,781	15.24	9
10	Activity Assistants	14,969	15,952	152,558	9.56	10
11	Social Service Workers	2,002	2,039	35,228	17.28	11
12	Dietician	1,835	1,835	28,252	15.40	12
13	Food Service Supervisor	1,803	1,882	36,062	19.16	13
14	Head Cook	2,065	2,144	23,427	10.93	14
15	Cook Helpers/Assistants	13,925	14,986	125,517	8.38	15
16	Dishwashers	12,597	13,297	87,165	6.56	16
17	Maintenance Workers	2,142	2,313	35,354	15.28	17
18	Housekeepers	28,091	29,961	199,761	6.67	18
19	Laundry	7,673	8,078	50,425	6.24	19
20	Administrator	1,830	2,129	99,934	46.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,471	12,233	163,140	13.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	221,456	236,099	$ 3,268,214 *	$ 13.84	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	221	$ 11,580	L1, C3	35
36	Medical Director	Monthly	18,500	L9, C3	36
37	Medical Records Consultant	19	1,070	L10, C3	37
38	Nurse Consultant	136	11,785	L10, C3	38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	3,185	L11, C3	44
45	Social Service Consultant	57	3,161	L12, C3	45
46	Other(specify)				46
47	Rehab Care Consultant	Monthly	5,037	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	499	$ 55,518		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,448	$ 48,954	L10, C3	50
51	Licensed Practical Nurses	2,865	51,563	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	5,313	$ 100,517		53

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Murphy	Administrator	0%	$ 37,836
Ted O'Brien	Administrator	0%	43,239
Esther Davis	Administrator	0%	9,814
Pam Harshbarger	Administrator	0%	9,045
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,934

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 728,194
TOTAL (agree to Schedule V, line 17, col. 3)	$ 728,194
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Avail Corporation	Accounting	$ 185
Altschuler, Melvoin & Glasser LLP	Accounting	14,864
American Express Tax & Bus Srv	Accounting	4,152
Grabowski Law Center, LLC	Collections	2,394
Personnel Planners	U/C Consulting	2,445
James Samatas	Legal	100
Katten Muchin Zavis Rosenman	Legal	924
Carol Jeschke	Staffing Consultant	719
Scott & Krause	Legal	228
Cassidy Schlade & Gloor	Legal	5,183
See attached Schedule F		28,899
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 60,093

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 56,856
Unemployment Compensation Insurance	72,865
FICA Taxes	245,589
Employee Health Insurance	53,886
Employee Meals	10,237
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contribution	7,197
Other Employee Benefits	20,856
Life Insurance	2,671
TOTAL (agree to Schedule V, line 22, col.8)	$ 470,157

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,500
Advertising: Employee Recruitment	44,948
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous dues & subscriptions	14
Miscellaneous licenses and permits	1,831
Allocated from Management Company	651
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 49,944

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,624
Allocated from Management Company	2,705
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,329

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Elmhurst, Inc.
Provider # 0037317
1/1/04 - 12/31/04

Schedule F

XIX. Support Schedules
C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	18,952
McLeod USA	Computer Consulting	405
Lanac	Computer Consulting	792
National Datacare Corporation	Computer Consulting	1,040
Answers on Demand	Computer Consulting	2,652
eHealth Solutions	Computer Consulting	3,600
Gigatrend	Computer Consulting	195
Information Controls, Inc.	Computer Consulting	867
AdminaStar Federal	Computer Consulting	396
Total, Other Professional Services		28,899
Total, Agrees to Schedule V, Line 19, Column 3		60,093
Allocated from management co.		
American Express Tax & Business Services	Accounting	224
Altschuler, Melvoin and Glasser LLP	Accounting	359
Account Temps	Accounting	611
Avail Corporation	Accounting	17
Doris Fischer	Medicaid Billing Consultant	1,572
Gene Whitehorn	Medicaid Billing Consultant	543
Susan Parker, LCSW	DNR Consulting	8
Personnel Planners	U/C Consulting	9
Gilson, Labus and Silverman	Accounting	185
James Samatas	Legal	26
Sachnoff and Weaver	Legal	733
ING / Pension Administrators	401 (k) Administration	642
Eric Haider	Consulting	19
Various	Computer Consulting	7,891
Allocated from building partnership		
James Samatas	Filing and recording fees	250
Tax Caps.Com	Real estate appraisal fees	1,048
Reclassifications		
Tax Caps.Com	Real estate Tax appeal	(1,048)
Nonallowable legal fees		
Grabowski Law Center, LLC	Legal-collection fees	(2,394)
Scott & Krause	Out of period consulting fees	(228)
Katten Muchin Zavis Roseman	Out of period legal fees	(689)
Total, Agrees to Schedule V, Line 19, Column 8		69,871

See accountants' compilation report

Facility Name & ID Number Lexington of Elmhurst # 0037317 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2							N/A						
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Elmhurst # 0037317 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **39,837** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **82,350**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **10,237** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **175**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	300,423	31,264	11,580	343,267	0	343,267	0	343,267
2. Food Purchase	0	236,451	0	236,451	0	236,451	-10,412	226,039
3. Housekeeping	199,761	27,020	0	226,781	0	226,781	217	226,998
4. Laundry	50,425	17,269	0	67,694	0	67,694	-1,030	66,664
5. Heat and Other Utilities	0	0	194,089	194,089	0	194,089	2,480	196,569
6. Maintenance	35,354	0	75,015	110,369	0	110,369	31,856	142,225
7. Other (specify)*	0	0	0	0	0	0	3,585	3,585
8. Total General Services	585,963	312,004	280,684	1,178,651	0	1,178,651	26,696	1,205,347
9. Medical Director	0	0	18,500	18,500	0	18,500	0	18,500
10. Nursing & Medical Records	2,203,610	144,318	147,238	2,495,166	0	2,495,166	41,879	2,537,045
10a. Therapy	0	0	668,468	668,468	0	668,468	0	668,468
11. Activities	180,339	19,291	3,185	202,815	0	202,815	0	202,815
12. Social Services	35,228	0	3,161	38,389	0	38,389	0	38,389
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	5,064	5,064
16. Total Health Care & Programs	2,419,177	163,609	840,552	3,423,338	0	3,423,338	46,943	3,470,281
17. Administrative	99,934	0	728,194	828,128	0	828,128	-657,708	170,420
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	60,093	60,093	0	60,093	9,778	69,871
20. Fees, Subscriptions & Promotion	0	0	50,293	50,293	0	50,293	-349	49,944
21. Clerical & General Office	163,140	33,576	16,936	213,652	0	213,652	198,938	412,590
22. Employee Benefits & Payroll	0	0	459,920	459,920	0	459,920	10,237	470,157
23. Inservice Training & Education	0	0	370	370	0	370	0	370
24. Travel and Seminar	0	0	3,624	3,624	0	3,624	2,705	6,329
25. Other Admin. Staff Trans	0	0	159	159	0	159	6,958	7,117
26. Insurance-Prop.Liab.Malpractice	0	0	171,434	171,434	0	171,434	3,098	174,532
27. Other (specify)*	0	0	0	0	0	0	30,549	30,549
28. Total General Adminis	263,074	33,576	1,491,023	1,787,673	0	1,787,673	-395,794	1,391,879
29. Total General Administrative	3,268,214	509,189	2,612,259	6,389,662	0	6,389,662	-322,155	6,067,507
30. Depreciation	0	0	51,704	51,704	0	51,704	140,679	192,383
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	951	951	0	951	234,318	235,269
33. Real Estate	0	0	0	0	0	0	61,212	61,212
34. Rent - Facility & Grounds	0	0	839,059	839,059	0	839,059	-838,060	999
35. Rent - Equipment & Vehicles	0	0	4,092	4,092	0	4,092	2,107	6,199
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	895,806	895,806	0	895,806	-399,744	496,062
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	243,388	814	244,202	0	244,202	0	244,202
40. Barber and Beauty Shop	0	0	30,640	30,640	0	30,640	0	30,640
41. Coffee and Gift Shops	0	0	1,977	1,977	0	1,977	0	1,977
42. Provider Participation	0	0	82,350	82,350	0	82,350	0	82,350
43. Other (specify):*	0	0	158,066	158,066	0	158,066	-158,066	0
44. Total Special Cost Ce	0	243,388	273,847	517,235	0	517,235	-158,066	359,169
45. Grand Total	3,268,214	752,577	3,781,912	7,802,703	0	7,802,703	-879,965	6,922,738

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	492,020	535,423
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,730,142	1,730,142
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	32,255	32,255
7. Other Prepaid Expenses	19,652	19,652
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	27,910
10. Total current assets	2,274,069	2,345,382
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	5,684	5,684
13. Land	0	1,289,511
14. Buildings, at Historical Cost	0	4,110,586
15. Leasehold Improvements, Historical Cost	413,380	578,905
16. Equipment, at Historical Cost	208,557	647,972
17. Accumulated Depreciation (book methods)	-210,104	-2,114,911
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	24,822	24,822
23. other (specify):	0	34,014
24. Total Long-Term Assets	442,339	4,576,583
25. Total Assets	2,716,408	6,921,965
CURRENT LIABILITIES		
26. Accounts Payable	378,073	378,073
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	175,000	175,000
30. Accrued Salaries Payable	150,276	150,276
31. Accrued Taxes Payable	9,932	9,932
32. Accrued Real Estate Taxes	0	66,000
33. Accrued Interest Payable	0	19,820
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	119,054	79,453
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	832,335	878,554
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	3,523,589
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	3,523,589
46.Total Liabilities	832,335	4,402,143
47.Total Equity	1,884,073	2,519,822
48.Total Liabilities and Equity	2,716,408	6,921,965

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	8,268,766
2. Discounts and Allowances for all Levels	-717,155
Subtotal - Inpatient Care	7,551,611
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,198,820
7. Oxygen	0
Subtotal - Anciliary Revenue	1,198,820
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	2,609
13. Barber and Beauty Care	37,857
14. Non-Patient Meals	175
15. Telephone, Television, and Radio	27
16. Rental of Facility Space	0
17. Sale of Drugs	279,771
18. Sale of Supplies to Non-Patients	0
19. Laboratory	14,419
20. Radiologyand X-Ray	6,825
21. Other Medical Services	34,087
22. Laundry	1,030
Subtotal - Other Operating Revenue	376,800
24. Contributions	0
25. Interest and Other Investments Income	10,753
Subtotal - Non-Operating Revenue	10,753
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1053
Subtotal - Other Revenue	1,053
30. Total Revenue	9,139,037
31. General Services	1,178,651
32. Health Care	3,423,338
33. General Administration	1,787,673
34. Ownership	895,806
35. Special Cost Centers	434,885
35. Provider Participation Fee	82,350
37. Other	0
40. Total Expenses	7,802,703
41. Income Before Income Taxes	1,336,334
42. Income Taxes	0
43. Net Income or Loss for the Year	1,336,334

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